

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

11467

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11461

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b 13-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 109 N.St. Johns Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 109 N. St. Johns Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES P. GRAY First Middle Last 4. DATE OF DEATH Aug. 21, 1966 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 11, 1904 9. AGE (In years last birthday) 61 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P. Telephone Co. 11. BIRTHPLACE (State or foreign country) Kentucky 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Resin D. Gray 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 252-03-8514		14. MOTHER'S MAIDEN NAME Lelia Mc Rae 17. INFORMANT Carl W. Kramer, Sykesville, Md Address Rt. 1 Box 114	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 44 Church Rd Address (Street, city, town, or county) Ellicott City, Md	
22. DATE SIGNED 8/2/66		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8-24-1966 23c. NAME OF CEMETERY OR CREMATORY Lorraine 23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md. Address F.C. Higinbotham, Ellicott City, Md.		25a. REC'D BY REGISTRAR DATE AUG 23 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

2000

• **CONCLUSIONS**

FOR STATE HEALTH DEPT.

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VR A15ME (S)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11468

Item 7 Film G380 9/6/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11464

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 No. Penfield Rd.				d. STREET ADDRESS 3 N. Penfield Road			
3. NAME OF DECEASED (Type or print) First MARION Middle H. Last KELLY				4. DATE OF DEATH Month 8 Day 30 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Toledo, Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Hill				14. MOTHER'S MAIDEN NAME Mary Sullivan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Robert W. Kelly, 3 N. Penfield Drive, E.C. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE Rudiger Breiteneker		EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D.		22. DATE SIGNED 8/31/66		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-2-1966		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City or Town) (County) (State) Elkridge, Md	
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				25a. REC'D BY REGISTRAR DATE SEP 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

13400

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11469

11463

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SAVAGE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 MADISON ST</u>				d. STREET ADDRESS <u>300 Madison St</u>			
3. NAME OF DECEASED (Type or print) First <u>Suzanne</u> Middle <u>B.</u> Last <u>Kinzie</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-15-01</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ft. Meade</u>		11. BIRTHPLACE (State or foreign country) <u>NEW HARTFORD, CONN USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ANDREW BSULLAK</u>				14. MOTHER'S MAIDEN NAME <u>ANNA BRASEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>041-26-3660</u>		17. INFORMANT <u>Donald R. Kinzie, Savage, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>Thomas F. Herbert, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>444 Church Rd, ELICOTT CITY, MD</u> Address (Street, city, town, or county) DATE SIGNED <u>8/25/66</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/66</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR <u>Dewitt Donaldson, 313 Talbot Ave, Laurel, Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 1 1966</u>			
24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>							

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11470

CERTIFICATE OF DEATH

11464

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT. # 1 WATERLOO ROAD		d. STREET ADDRESS RT. # 1 WATERLOO ROAD	
3. NAME OF DECEASED (Type or print) First KATIE Middle NEIGHOFF Last NEIGHOFF		4. DATE OF DEATH Month AUGUST Day 7 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1885
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH BULLINGER		14. MOTHER'S MAIDEN NAME SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. WALTER NEIGHOFF, 3618 COOLIDGE AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1, 1964 , to July 7, 1966 , that (I) (we) last saw the deceased alive on July 7, 1966 , and that death occurred at 7:15 M, from causes and on the date stated above.			
22a. SIGNATURE Frank E. Shipley		22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type) FRANK E. SHIPLEY
22d. ADDRESS 11 BALTIMORE STREET-SAVAGE, MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8-10-66	23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEMETERY	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229		25a. REC'D BY REGISTRAR AUG 11 1966	
25b. REGISTRAR'S SIGNATURE Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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FOR STATE
HEALTH DEPT.

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VR A15ME
5M 1/63

11471
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Resigned to 60-day admission) a. STATE <u>md</u> b. COUNTY <u>Bre Lee Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage, Md</u>		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 Jefferson st</u>				d. STREET ADDRESS <u>15 Jefferson st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Karl Jonathan SAMUELSON</u>				4. DATE OF DEATH Month Day Year <u>Aug. 21 1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1887</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sweden</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nilson</u>				14. MOTHER'S MAIDEN NAME <u>Maria Samuelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>037-07-6460</u>		17. INFORMANT Address <u>E. Derthick, 15 Jefferson St. Savage, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>							<u>30 min.</u>
4221 } CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u>							<u>5 yrs.</u>
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Thomas L. Herbert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Thomas P. Herbert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>8/21/66</u>			
				Address (Street, city, town, or county) <u>444 Church Rd. Ellicott City, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 25, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR <u>F. Busch's sons Hyattsville Md</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 24 1966</u>			
				24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

1100

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "DATE" are faintly visible.]

DATE	TIME	REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11472					11466				
1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge c. LENGTH OF STAY IN 1b 13-1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1942 Furnace Ave					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkridge d. STREET ADDRESS 1942 Furnace Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLES FRANCIS WEBER			First Middle Last		4. DATE OF DEATH Aug. 28, 1966		Month Day Year 19		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1904		9. AGE (in years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles T. Weber					14. MOTHER'S MAIDEN NAME Alice Moore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-14-6556		17. INFORMANT Mrs. Emma M. Weber, 1942 Furnace Ave. Elkridge				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Cardio Vascular Disease 5 yrs DUE TO (b) General Arteriosclerosis DUE TO (c) Diabetes Mellitus CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan, 1964 to Aug 28, 1966 , that (I) (we) last saw the deceased alive on Aug 28, 1966 , and that death occurred at 7 P.M. from the causes and on the date stated above.									
22a. SIGNATURE B. B. Brumbaugh				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) B. B. Brumbaugh				22d. ADDRESS 1800 Main St Elkridge 27 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-31-1966		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION (City, town or county) (State) Elkridge, Md		
24. FUNERAL DIRECTOR F. C. Higginbotham				ADDRESS Ellicott City, Md.		25a. REC'D BY REGISTRAR AUG 31 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

11400

Howland

Howland

Howland

Elizabeth

Elizabeth

10000 Avenue

10000 Avenue

Aug. 28, 1900

CHARLES FRANKLIN WEBER

July 21, 1900

White

Howland

Painter

Alice Moore

Charles E. Weber

Mr. James M. Weber, 10000 Avenue, Elizabeth

Ho

Elizabeth

Elizabeth

10-21-1900

Elizabeth

10000 Avenue, Elizabeth, N.J.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. To the registrar, to the funeral director, or to the funeral director's office. File pages 1 and 2 with the registrar for a burial-transit permit. File pages 3 and 4 with the registrar for a removal.

VS. ATSMES
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item #12 Film #G380 9/19/66pc

Reg. Dist. No.

11473

11467

1. PLACE OF DEATH a. COUNTY Howard Co. ELLICOTT CITY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE M.D. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) # 5 GRACE CT.		d. STREET ADDRESS # 5 GRACE CT	
3. NAME OF DECEASED (Type or print) First Joseph Middle Wisniewski Last		4. DATE OF DEATH Month Aug Day 22 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? - U.S.A.	
13. FATHER'S NAME JOHN WISNIEWSKI		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address RECILIA STROZYK- 5 GRACE CT ELLICOTT ST.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 160X DUE TO Carcinoma, lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) 8 mos. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Thomas F. Herbert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Thomas F. Herbert, MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 44 Church Rd. 8/22/66	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ELLICOTT CITY, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-66	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		22d. LOCATION (City, town, or county) (State) Baltimore MD	
23. FUNERAL DIRECTOR'S SIGNATURE JW Bzowski		24a. REC'D BY REGISTRAR DATE AUG 25 1966	
24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

11-011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY AND COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGERY		HISTORY OF DRUGS		HISTORY OF ALCOHOL		HISTORY OF TOBACCO		HISTORY OF OTHER HABITS		HISTORY OF OTHER FACTORS		HISTORY OF OTHER FACTORS	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGIC EXAMINATIONS		PATHOLOGIC EXAMINATIONS		TOXICOLOGIC EXAMINATIONS		OTHER EXAMINATIONS		OTHER EXAMINATIONS		OTHER EXAMINATIONS		OTHER EXAMINATIONS	
POSTMORTEM EXAMINATION		HISTOPATHOLOGIC EXAMINATIONS		MICROSCOPIC EXAMINATIONS		CYTOLOGIC EXAMINATIONS		IMMUNOLOGIC EXAMINATIONS		GENETIC EXAMINATIONS		OTHER EXAMINATIONS		OTHER EXAMINATIONS		OTHER EXAMINATIONS	
FINDINGS		DISCUSSION		CONCLUSIONS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER	

GIVEN UNDER MY HAND AND SEAL OF OFFICE, THIS 11th DAY OF NOVEMBER, 1961, AT THE CITY AND COUNTY OF LOS ANGELES, STATE OF CALIFORNIA.